Ade Medical Group

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my protected health information as described below

Make sure ALL blanks are filled in. Failure to do so could prevent or delay processing.

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____
(Street, City, State, and Zip Code)

TELEPHONE NO: ( ) _____ PREVIOUS NAME (if applicable): _____

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

Provider releasing the information:

The following individual or organization is authorized to release my protected health information:

Name of Individual(s): _____

Provider(s), or Organization(s): _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Requestor (Where the information is being sent):

The following individual or organization is authorized to receive my protected health information:

Name of Individual(s): _____

Provider(s), or Organization(s): _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

Information Requested:

Service Dates: _____

_____ Complete records for the date above or:

_____ Lab data (dates): _____

_____ EKG data (dates): _____

_____ Progress Note data (dates): _____

_____ Imaging data (dates): _____

_____ Consultation data (dates): _____

(PLEASE SEE REVESE SIDE OF FORM FOR COMPLETION)

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW:

I specifically authorize the release of information relating to (indicate YES or NO for each):

_____ Substance Abuse (Drug/Alcohol)

_____ Mental Health (includes psychological testing/visits)

_____ Sexually Transmitted Infections/HIV/AIDS related testing/notes

Purpose of Release:
My protected health information will be used or disclosed for the following purpose(s):

_____

_____

_____

(Describe the reason for each use and disclosure of the protected health information). If you do not wish to describe the purpose, you may indicate "at the request of the individual".

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to Ade Medical Group, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that already has used or disclosed, relying on this authorization.

This authorization expires: _____, (list expiration date or event)
This authorization will expire in one year from signature date, if no expiration date or event is listed

_____ _____
Signature of Patient or Personal Representative * Date

_____
Print Name of Patient or Personal Representative *

_____
Description of Personal Representative's Authority

* This form should be signed by the patient. If the patient is unable to sign a Personal Representative may sign on their behalf, if the representative has the appropriate authority. A copy of any such paperwork granting such authority should also be submitted.